Columbus Civil Service Commission
50 West Gay Street, Room 600
Columbus, Ohio 43215

Americans With Disabilities Act
Step I –Provider Statement

Provider, please return this form to the applicant.
Applicant, please return this form to Civil Service on or before _____

The Columbus Civil Service Commission accommodates applicants according to the requirements of the Americans with Disabilities Act (ADA). An applicant who requests such accommodation must demonstrate that he or she is covered by the law. As a licensed medical provider, you are being asked to provide information to aid the Commission in making an appropriate determination regarding the candidate's request. Please return the completed form to the applicant so that the form can be returned to Civil Service by the date noted above.

Part A – To be completed by the job applicant.

1. Applicant Name:

2. Address:

3. Telephone Number:

Part B – To be completed by a licensed provider of medical services.

1. Provider Name:

2. Address:

3. Telephone Number:

4. Licensing Board:

5. License State & Number:

6. Diagnosis of Applicant's Disability:

7. Date of Diagnosis:

8. Name of Provider making diagnosis if other than this provider:

9. How long have you treated the applicant for this disability?

10: What methods did you use to diagnose the disability? In general, how severe is the disability? For psychological or psychiatric disabilities, what instruments or methods were used to assess the disability?

_____

_____

_____

_____

11. How is the disability currently being treated? If known, please include current job title, current employment accommodations, and a statement about the effectiveness of the accommodations.

_____

_____

_____

_____

I affirm that the information provided here is accurate, as I know it.

Provider Signature	Date

Thank you for assisting the applicant and Civil Service Commission in addressing this matter. If you have questions about the Commission's policies or this form, please call Lynn Carter at (614) 645-3902.

If the applicant is found to be covered by the ADA Act, you may be asked to recommend appropriate accommodations.

FOR CIVIL SERVICE COMMISSION USE ONLY

Review Date: _____

Determination: Covered ☐   Not Covered ☐

Reviewed by: _____

Comments: _____

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